Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MONZER H YAZJI MD
502 SOUTH CLOSNER
EDINBURG TEXAS 78539

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-13-1086-01

MFDR Date Received
December 20, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Request for Reconsideration letter dated November 15, 2012: "You initially denied this bill on EOB dated 09-28-12 because, 'Claim/Service Lacks Information Needed for Adjudication.' Therefore, the medical records were submitted. Now, you have another reason to deny this claim that [sic] so we are asking you to review it once more to avoid the MDR process. After an internal audit of this account we realized we billed incorrectly. This was a posting error on our part and a correction has been made. Please see the attached HCFA to reflect the correct CPT code 97002 which we should have initially billed instead of CPT code 97001."

Amount in Dispute: $165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The office received a third submission on 11/26/2012 where the provider corrected the CPT code to reflect CPT Code 97002 for a physical therapy re-evaluation however this corrected bill was received 118 days from date of service, minus 5 days for mailing which indicates the bill was 'sent' 113 days from date of service and not received within the 95 day time frame."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2012	Physical Therapy Re-Evaluation (97002)	$165.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 28, 2012 for CPT code 97001
   - 16 – Claim/service lacks information which is needed for adjudication, remark codes whenever appropriate.
   - The required documentation was not submitted with the bill. Please attach and resubmit bill to carrier for further review.

   Explanation of benefits dated October 26, 2012 for CPT code 97001
   - 125 – Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remark codes whenever appropriate
   - 17 – Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - Documentation supports services of a re-evaluation of physical therapy and/or the initial pt eval has already been established by this provider for w/c injury.

   Explanation of benefits dated December 7, 2012 for CPT code 97002

   - 29 – Time limit for filing has expired
   - The provider has resubmitted this bill, but has removed/changed the diagnosis code, CPT/HCPC code(s) and/or total bill charge amount, thus making it a new bill and subject to the 95 day timely filing rule

Issues

1. What CPT code is in dispute?
2. What is the timely filing deadline applicable to the medical bills for the services in dispute?
3. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. The requestor disputes nonpayment of "Physical Therapy Re-Evaluation."

   CPT code 97001 is defined as "Physical therapy evaluation."

   CPT Code 97002 is defined as "Physical therapy re-evaluation", the requestor has identified on the table of "Physical Therapy Re-Evaluation" as the item in dispute, and therefore, the division will review non-payment of CPT code 97002.
2. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
3. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 26, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.